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Case Study

A Case of Phobic Postural Vertigo Caused by Obsessive Thoughts and Psychological Distress, in the Indian Subcontinent

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ABSTRACT

Dizziness is one of the most common symptoms in primary care and can be associated with otologic, neurologic, and psychiatric conditions, (Furman & Jacob, 2001). Phobic postural vertigo is a term used to define a population with dizziness and avoidance behaviour often as a consequence of a vestibular disorder, (Holmberg et al., 2006). It is characterised by a combination of non-rotational vertigo with subjective postural and gait instability, mainly in patients with an obsessive-compulsive personality, (Brandt, T., Huppert, D. & Dieterich, M., 1994). In this paper, we present a case of Phobic Postural Vertigo (PPV) caused by obsessive thoughts and psychological distress with primary gain as a motivating and maintaining factor. G, a 32-year-old male presented with complaints of panic symptoms, headache, physical weakness, and lack of self-esteem with a history of obsessive traits and was diagnosed with PPV after no clinical vestibular abnormalities were found by the otolaryngology department. Currently, the patient is on medication for his obsessive features, and an eclectic therapeutic intervention plan which includes cognitive behavioural therapy as the anchor and goals for the patient's treatment are discussed.

Keywords: *Phobic Postural Vertigo, Obsessive Thoughts, Psychological Distress, Indian Subcontinent*

Phobic postural vertigo is a term used to define a population with dizziness and avoidance behaviour often as a consequence of a vestibular disorder, (Holmberg et al., 2006). It is characterised by a combination of non-rotational vertigo with subjective postural and gait instability, mainly in patients with an obsessive-compulsive personality, (Brandt, T., Huppert, D. & Dieterich, M., 1994). Vestibular vertigo is common in the general population, affecting more than 5% of adults in 1 year (Neuhauser et al., 2005). Patients suffering from phobic postural vertigo are often encountered in the department of otorhinolaryngology and in the absence of any organic abnormalities are referred to the department of psychology with a provisional diagnosis of psychosomatic disorder, but are often misdiagnosed. The mono-symptomatic disturbance of balance manifests with superimposed attacks that occur with and without recognisable provoking factors in the same

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patient and are experienced with and without accompanying excess anxiety, misleading both patient and physician to a false diagnosis of organic disease, (Brandt et al., 1994). The diagnosis of PPV was given by (Brandt et al., 1994) based mainly on the following six characteristic features:

1. Dizziness and subjective disturbance of balance in the upright posture and during gait, despite normal clinical balance tests.
2. Postural vertigo is described as fluctuating unsteadiness, often taking the form of attacks or sometimes the perception of illusory body perturbations for mere fractions of seconds.
3. Anxiety and distressing vegetative symptoms accompanying and subsequent to vertigo elicited by direct questioning, although most patients experience vertigo attacks both, with and without excess anxiety.
4. Vertigo attacks that can occur spontaneously but upon specific questioning are found to be almost invariably associated with particular constellations of perceptual stimuli (bridges, staircases, empty rooms, streets, driving a car) or social situations (department store, restaurant, concert, meeting, reception) from which the patients have difficulty in withdrawing and which they recognize as provoking factors. There is a tendency for rapid conditioning, generalisation and avoidance behaviour to develop.
5. Typically, an obsessive-compulsive type personality in patients is often found to have affective lability and mild (reactive) depression.
6. Frequently, the onset of the condition follows periods of particular stress or after the patient has experienced an illness, usually a vestibular disorder.

A diagnostic validation study of patients with vestibular symptoms showed that 60% had clinically significant anxiety symptoms and 45% had clinically significant depression symptoms, but importantly, 25% had no psychiatric morbidity on self-report measures, standardized clinician-administered psychiatric diagnostic screening, or psychosomatic examinations. (Kapfhammer et al., 1997) found that a great majority of PPV patients showed features of an obsessive-compulsive personality type and personality features like narcissistic, histrionic, dependent, avoidant, passive–aggressive were prevalent, (Staab, 2012). The description of phobic postural vertigo by (Staab et al., 2017) includes a diverse collection of behavioural symptoms, such as obsessive-compulsive personality traits, labile affect, anxiety, avoidance, and mild depression. PPV may be triggered initially by vestibular disorders, medical illnesses, or psychological stress, (Staab, 2012). Stress is widely considered a trigger of PPV, and classical and operant conditioning are thought to be its pathophysiologic mechanisms. The most frequent underlying psychiatric disorders are anxiety and depression as well as dissociative somatoform disorders, (Huppert et al., 2005). Coexisting anxiety and depressive disorders also are common in patients with functional dizziness, (Dieterich & Staab, 2017).

The postural behavior and muscle tension in patients with PPV might have a strong impact on the effect of individual psychological treatment. PPV should not be seen as a phobic reaction to external stimuli but rather as a multidimensional problem involving vestibular, postural, proprioceptive, cognitive, and emotional factors. Vestibular rehabilitation exercises, physiotherapy, and medication with SSRIs are probably necessary components of treatment (Holmberg et al., 2006). A multidisciplinary approach is recommended with cognitive behavioural therapy as the central therapeutic technique. In a study of 78 patients, 22% of the patients became symptom-free, 50% were considerably improved, and 28% reported no

improvement or even worsening of the condition within an average follow-up period of 2.5 years (6 months to 5.5 years). The improvement or remission of PPV usually occurred within days to weeks following diagnosis and the suggestive treatment described above. Improvement usually remained stable and ameliorated both professional and social activities considerably. The majority of patients with PPV felt fit for work after getting treatment, (Brandt et al., 1994).

Case Presentation

G, a 32-year-old male was presented with complaints of panic symptoms, headache, physical weakness, lack of self-esteem, and a history of obsessive traits. He is unmarried, lives with his family, and works in a private company as a statistics tutor. On investigation, it was found that his psychopathological symptoms started at the age of 16 years when he fairly developed an insight into homosexuality and has questions about his sexual orientation.

After the unfurling of the realization, he started to develop symptoms of depressive mood with irritable temperament, and sudden outbursts of anger which led to a dysfunctional relationship with his parents. G took approximately 12 years to come out about his sexual preference to his parents. However, they were not accepting of his sexuality and rejected the idea initially and the patient thereon, developed a fear of acceptance and issues related to confidence, self-esteem, negative self-image, unstable identity, and constant and irrational thinking with magnified assumptions. The patient also developed a maladaptive thought process pattern regarding physical beauty standards and their importance in relationships. On interrogation, it was found out that G has a history of impulsive sexual relationships and trivializing the relationship, leading to multiple unsuccessful attempts for constant reassurance, usually leading to disappointments. These incidents have formed a constant negative pattern of thinking toward his partners, and made him feels feel unsafe. He usually refers to his partners to be settled in another world, and also believes that it's the fault "in his stars" which leads to breakups.

During these 12 years, the patient did not seek any structured medical professional help except for a few irregular visits to a counselling psychologist. The patient came in for his first consultation in March 2021 with complaints of restlessness, anxiety, forgetfulness, and constant headache with dizziness and imbalance. After taking a thorough Case History and a Mental Status Examination, G was prescribed Sertraline (50mg) and Risperidone (0.5mg) over the period of 1 month. His routine blood workup was suggestive of low levels of vitamin B12 and D3, for which he was prescribed appropriate supplements. After a month, the dosage of Sertraline was increased to 150mg (as per the target dose prescription) for his obsessive features. He responded well to the above treatment and was also started on Psychotherapy post-follow-up. With passing time, G constantly reported symptoms of dizziness and lightheadedness, loss of balance, physical perturbations, and feelings of fainting, so he was referred to an otolaryngologist for the investigation of these symptoms. After a thorough investigation by the otolaryngologist department (Posturography, Dix-Hallpike Maneuver, and some clinical hearing and balance tests), it was concluded that there was no organic cause present and the vestibular symptoms were caused by psychological imbalances.

Upon a detailed clinical investigation of his psychological state, many developed specific fears were found including, fear of dying by meeting an accident, fear of losing his job, fear

of reaching late at the workplace, fear of his sexuality being revealed, fear of ejaculation sooner than desired, fear of adjustment and a fear of rejection. The patient has also reported depressive symptoms including both, physical and psychological symptoms. The patient has also presumed a brain tumor to be the cause of his vestibular symptoms, which is undiagnosed and not based on any medical evidence. He has a constant fear of being rejected for his sexual preference and a fixation on physical appearance which leads him to an overwhelming negative thinking loop leading to dizziness and imbalance.

DISCUSSION

G was diagnosed with Phobic Postural Vertigo according to the diagnostic criteria given by (Brandt, T. 1996) based on the following characteristic features-

1. Dizziness and subjective disturbance of balance in the upright posture and during gait, despite normal clinical balance tests.
2. Postural vertigo is described as fluctuating unsteadiness, often taking the form of attacks or sometimes the perception of illusory body perturbations for mere fractions of seconds.
3. Anxiety and distressing vegetative symptoms accompanying and subsequent to vertigo.
4. Vertigo attacks that occur spontaneously but upon specific questioning are found to be almost invariably associated with particular constellations of perceptual stimuli from which the patient has difficulty in withdrawing and which he recognizes as provoking factors. There is a tendency for rapid conditioning, generalization, and avoidance behaviour to develop.
5. An obsessive-compulsive type personality and found to have affective lability and mild depression.
6. The onset of the condition following periods of particular stress.

The patient has specific recurrent fears that are irrational and shape his cognitive process and behaviour. These fears have a common theme of death, getting exposed, losing stability, failure in sexual encounters, and rejection. These fears are maladaptive and act as contributing factors to his vestibular symptoms leading to a negative cognitive triad of negative feelings about himself, the future, and the world, ultimately altering the perception of and affecting the interpersonal relationships in his life. The patient also has mild depressive symptoms, both physical and psychological.

Physical symptoms:

- Decreased energy
- Increased fatigue
- Crying spells

Psychological symptoms:

- Loss of interest in activities and people
- Hopelessness about the future
- Lower mood
- Increased frustration
- Obsessive overthinking
- Lowered decision-making abilities
- Lower self-esteem
- Thoughts of people dying

- Reduced emotional affect
- Suicidal Ideation

The patient's vestibular symptoms are triggered by excessive distressing thoughts about the responsibilities put upon him by society, and his obsession with somatic symptoms work as the maintaining factor for the phobic postural vertigo. The patient is fixated on a false belief about having a terminal illness related to his brain. The dizziness and fainting also serve him as a primary gain which refers to a decrease in anxiety (gain) from an unconscious defensive operation, which then causes a physical or conversion symptom, e.g. an arm is voluntarily paralyzed because it was used to hurt somebody, thereby allaying guilt and anxiety, (Fishbain DA, et al., 1995). The patient was prescribed Sertraline (50mg) and Risperidone (0.5mg) over the period of 1 month. His routine blood workup was suggestive of low levels of vitamin B12 and D3, for which he was prescribed appropriate supplements. After a month from the initial consultation, the dosage of Sertraline was increased to 150mg (as per the target dose prescription) for his obsessive features. A small study supported a combination of psychoeducation, cognitive-behavioural therapy, vestibular habituation, and antidepressant drugs when needed, (Tschan et al., 2012). (Sardinha et al., 2009) presented a case of Phobic Postural Vertigo where significant improvement was achieved only after the addition of cognitive behavioural therapy to the traditional intervention techniques. A study showed that, on using a flexible treatment plan for an average of 32 months, 78% of patients reported sustained reductions in dizziness, (Schaaf & Hesse, 2014). This suggests that a flexible individualized treatment plan based on the symptoms and the needs of the patient is would be the best course of therapy as of now.

The patient's long-term therapeutic treatment goals include:

- Asses and increase the level of insight about the present psychological problems.
- Reduce the duration, frequency, and intensity of obsessive thoughts.
- Reduce time involved and interference of obsessions.
- Reduce key life conflicts and the emotional stress that fuels daily psychological imbalance.
- Acceptance of obsessive thoughts without acting on them and commitment to a value-driven life.
- Explore, address, and correct the cognitive distortions and negative thinking patterns that are persistent.

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Conflict of Interest

The authors declare that they have no competing interests. No specific grant from any funding agency in the public, commercial, or not-for-profit sectors exists.

Data Availability

All data generated or analysed during this study are included in this published article.

Consent

A written informed consent of publication was obtained directly by the involved subjects. A copy of the consent forms is available for the editor to review upon request.

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